CITY OF MINNEAPOLIS - BENEFIT ENROLLMENT/CHANGE FORM

Employee Name _____ Employee ID # _____ Effective Date _____

Home Phone _____ Work Phone _____

Enrollment/Change Reason: Check one and include documentation required to complete the change. If required documentation is not included with this form, your change request will not be processed.

	Change Reason	Required Documentation
	Marriage	Marriage certificate If adding a step-child, include a copy of child's birth certificate naming your spouse as child's parent If adding a grandchild, see below for required documentation
	Divorce	Divorce decree, first and last pages and any pages that mention benefits and ex-spouse address
	Birth or Adoption	Birth certificate or adoption papers naming you as parent If adding a spouse, copy of your marriage certificate and front page of most recent federal tax return *
	Grandchild	Copy of birth certificate naming your child as parent, and Copy of federal tax return listing child as your dependent (not required for new born) and a copy (listing your address) of current report card, school registration, day care statement or physician/hospital bill
	Death	Copy of death certificate
	Change in spouse's employment	Letter from employer listing names of all covered persons and effective date of coverage change AND If adding, spouse copy of marriage certificate and front page of most recent federal tax return* If adding child or grandchild, see above for documentation requirements
	Gain or loss of medical assistance	Letter from your county indicating date coverage ended or started If adding a spouse, child or grandchild see above for documentation requirements
	Medicare enrollment	Proof of Medicare coverage showing effective date

*blackout all financial information and social security numbers on federal tax return

CURRENT MEDICAL COVERAGE:

___ WAIVE ___ Single ___ Family

___ Medica Elect (Standard or Wellness)
___ Medica Essential (Standard or Wellness)
___ Medica Choice Passport (Standard or Wellness)

CHANGE MEDICAL COVERAGE TO:

___ WAIVE ___ Single ___ Family

___ Medica Elect (Standard or Wellness)
___ Medica Essential (Standard or Wellness)
___ Medica Choice Passport (Standard or Wellness)

CURRENT DENTAL COVERAGE:

___ Single ___ Family

CHANGE DENTAL COVERAGE TO:

___ Single ___ Family

FLEXIBLE SPENDING ACCOUNTS

___ Decrease ___ Increase (or enroll) Health Care Flexible Spending Account $ _____ New Annual Amount

___ Decrease ___ Increase (or enroll) Dependent Care Spending Account $ _____ New Annual Amount

DEPENDENTS: Complete the information in the chart below. Add additional sheets if necessary.

NAME	M/F	RELATION-SHIP	Social Security # *Required for all dependents*	DATE OF BIRTH	MEDICAL		DENTAL		*PRIMARY CLINIC NUMBER** ***(11 digits)***
					Enroll	Remove	Enroll	Remove	

* **Primary care clinic elections for Elect and Essential networks:** If you elect either Elect or Essential, all family members must choose a primary care clinic within either the Elect or the Essential network. You cannot split family members between the networks. To find network providers, visit minneapolismn.gov/hr/benefits. If you enroll in Elect or Essential and do not provide a valid clinic number, a clinic will be randomly assigned to you.

I hereby authorize the City of Minneapolis to deduct required pre-tax premiums for coverage elected above. Further, I understand that if I do not return a completed a benefit enrollment change form to Human Resources within 30 days of the event (exceptions to the 30 day election date for medical and dental are birth, adoption and foster care placement), I will not be eligible to change my benefit options until the next Open Enrollment period.

_____ _____

Employee Signature **Date**

Some of the requested information on this form is private data under the Minnesota Government Data Practices Act, Minn. Stat. Chapter 13. The data requested allows Benefit staff to verify eligibility and enroll you and your dependents in health plan(s) and allows the plan provider(s) the ability to establish an enrollment record for you and your dependents. You are not required to provide this information, however, failure to do so may result in ineligibility and non-enrollment. This form may be available to City and plan provider employees or agents, labor union representatives, arbitrators and administrative hearing examiners, State and Federal courts, and attorneys representing any of the mentioned individuals or entities, or to others through subpoena or pursuant to Federal and State law.

Fax completed form to **612-673-2533** or **mail** completed form to: **City of Minneapolis, Human Resources-Benefits, 250 S 4th Street, Room 100, Minneapolis MN 55415. Call 612-673-3333 with questions.**

Revised 7/2015